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The law requires that the death certificate be executed within 24 hours after the death of the decedent. It may be obtained by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00001											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>						d. STREET ADDRESS <b>East Main</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>C.</b> Last <b>Abbott</b>						4. DATE OF DEATH Month <b>January</b> Day <b>13</b> , Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 15, 1872</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Judge</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Orphans Court</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Galston, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Abbott</b>						14. MOTHER'S MAIDEN NAME <b>Lilias Campbell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>Miss. Lilias Abbott</b>				Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial Ischemia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Atherosclerosis + coronary insufficiency</b> DUE TO <b>X</b> (c) <b>X</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Cerebral Thrombosis</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1956</b> to <b>Jan. 13, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred at <b>5:20 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>L. R. Miles, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1.15.62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. R. MILES, JR. M.D.</b>						22d. ADDRESS <b>Lonaconing Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Moscow, Md.</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>						ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	



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Allegany

Prosperity

Miners Hospital

William

White

Male

Judge

William Abbott

Illias Campbell

no

Miss. Illias Abbott  
Daughter

Longmont, W.

George Johnson

George Johnson

George Johnson

1902

Longmont

Illias

Illias

George Johnson

Longmont, W.

Longmont, W.  
Illias  
Prosperity  
Miners Hospital  
William  
White  
Male  
Judge  
William Abbott  
Illias Campbell  
Miss. Illias Abbott  
Daughter  
Longmont, W.

January 13, 1902  
Abbott  
January 13, 1902  
White  
January 13, 1902  
Illias Campbell  
U.S.A.

George Johnson  
Longmont, W.  
Illias  
Prosperity  
Miners Hospital  
William  
White  
Male  
Judge  
William Abbott  
Illias Campbell  
Miss. Illias Abbott  
Daughter  
Longmont, W.

TO HOSPITAL OR AFTER DEATH BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00002

## CERTIFICATE OF DEATH

00002

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN IL <b>12 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>512 CUMBERLAND STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>C</b> Last <b>ANKENEY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1962</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 6, 1876</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN F. CHARLES</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. GARDNER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Congestive Heart Failure</b> 422 DUE TO <b>arteriosclerotic cardiovascular disease 4 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Macrocytic anemia (Permethion / Controlled)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1934</b> , 19 <b>3 Jan.</b> , 19 <b>07</b> that (I) (we) last saw the deceased alive on <b>2 Jan. 1962</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Alfred Van Ormer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3 Jan. 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/4/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Clear Spring Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>				ADDRESS <b>Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

00002

STATE OF MARYLAND

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GRACE

MINNEAPOLIS

JANUARY

WHITE

JULY 6, 1918

MARYLAND

HOSPITAL

MARY E. GARDNER

BENJAMIN E. CHARLES

MEMORIAL HOSPITAL - GUNTERLAND, MARYLAND

DR. V. A. VAN CIVER

152 E. CENTRAL STREET, GUNTERLAND, MD.

00003

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00003

Item 14 File # G305 1/29/62 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ECKHART</b>		c. LENGTH OF STAY IN lb <b>49 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>ARNONE</b> Last <b>ARNONE</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>19</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 20TH, 1888</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET.-MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINING</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH ARNONE</b>		14. MOTHER'S MAIDEN NAME <b>Sarafina Filcatti</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ENORDO ARNONE, 72 ARMSTRONG ST., F'BG.MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sunshot wound of Skull</b> DUE TO <b>Laceration of Brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot self in RT Ear with 22 Revolver</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:30</b> a. m. <b>Jan 14</b> 19 <b>62</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Yard</b>		20f. (City or town) <b>Eckhart Allegany Md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>W O McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W O McLane MD asst</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-22-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>		22d. LOCATION (City, town, or county) <b>FROSTBURG, MD.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. P. Burt</b>		ADDRESS <b>FROSTBURG, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE N 23 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Christ S. Thomas</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00004

1. PLACE OF DEATH a. COUNTY Alleghany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alleghany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Months 02		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Crescent St.				d. STREET ADDRESS 1 8 Crescent		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Henry Last Atkinson				4. DATE OF DEATH Month January Day 15 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1891	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry W. Atkinson				14. MOTHER'S MAIDEN NAME Mary E. Morrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address Mrs Beverly Atkinson Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO (b) Partial paralysis legs, bladder, rectum DUE TO (c) Extra Dural Spinal Sarcoma L3-L5						INTERVAL BETWEEN ONSET AND DEATH 3 years 9 years 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 25, 1954, to Jan 15, 1962, that I last saw the deceased alive on Jan 15, 1962, and that death occurred at 4:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE R. Rhett Rathbone M.D.				122 S. Centre Street			
PHYSICIAN'S NAME (Type) Dr. R. Rhett Rathbone				Cumberland, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-62		22c. NAME OF CEMETERY OR CREMATORY I.O.O.F.		22d. LOCATION (City, town, or county) (State) Elk Garden W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Prith Sr.				ADDRESS Kitzmilller, Md.		24a. REC'D BY REGISTRAR JAN 22 '62	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00005  
CERTIFICATE OF DEATH  
00005

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>10/17/1956</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Alice R. Barrett</b>		4. DATE OF DEATH <b>January 29, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionery</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Savage, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James E. Barrett</b>		14. MOTHER'S MAIDEN NAME <b>Mary V. Luckey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
<b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Chn, degenerative</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerosis &amp; Hypertension</b> DUE TO (c) <b>Cerebral Hemorrhage, Left Hemiplegia</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/17/56</b> to <b>1/29/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>1/29/62</b> , 19....., and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>1/29/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Feb 1-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST PATRICKS</b>	23d. LOCATION (City, town or county) (State) <b>MT. SAVAGE MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Duvet</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 2 '62</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>	

M

00002

Allegany

Maryland

Allegany

Comberland

10/17/55

Mr. Savage

Allegany County Infirmary

Alice

R.

Barnett

January 29, 55

55

Female White

3/31/1888

73

Retired: Clerk

Mr. Savage, Maryland

U. S. A.

James E. Barnett

Mary V. Loney

Comberland, Md.

Allegany County Infirmary records.

1/23/55

10/17/55  
8:00 A.M.

1/23/55

Dr. Joe B. Mathews

19 Green St., Comberland, Md.

1/23/55

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>000006</div> <div> <div>000006</div> <div>000006</div> </div> </div> <div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div> <div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> </div> <div> <div>15</div> <div>16</div> </div> <div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> </div> <div> <div>21</div> <div>22</div> </div> <div> <div>23</div> <div>24</div> </div> <div> <div>25</div> <div>26</div> </div> <div> <div>27</div> <div>28</div> </div> <div> <div>29</div> <div>30</div> </div> <div> <div>31</div> <div>32</div> </div> <div> <div>33</div> <div>34</div> </div> <div> <div>35</div> <div>36</div> </div> <div> <div>37</div> <div>38</div> </div> <div> <div>39</div> <div>40</div> </div> <div> <div>41</div> <div>42</div> </div> <div> <div>43</div> <div>44</div> </div> <div> 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Male

White

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(100)

*[Faint handwritten notes and signatures]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00007

00007

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>1 534 FORT AVENUE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVENUES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN E. BENNETT</b>		First Middle Last		4. DATE OF DEATH <b>JANUARY 14, 1962.</b>		Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 1, 1886</b>			
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>JOHN BENNETT</b>				14. MOTHER'S MAIDEN NAME <b>ANN SOWERS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151X Metastatic Carc of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14</b> , 19 <b>62</b> to <b>Jan 14</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>Jan 14</b> , 19 <b>62</b> and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Blane M. Schindler</b>				22b. DATE SIGNED <b>1/16/62</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. BLANE M. SCHINDLER</b>			
22d. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 17, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Hafer Cumberland Md</b>				25a. REC'D BY REGISTRAR <b>JAN 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll S. Harris</b>			

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CENTRAL CASE ON BEHALF

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ALLIANCE

MARYLAND

ALLIANCE

CONFIDENTIAL

2 DAYS

CONFIDENTIAL

3000 E. WICK AVENUE

3000 E. WICK AVENUE

JOHN

RENEE

RENEE

WHITE

APRIL 1, 1966

75

RENEE

JOHN

RENEE

RENEE

DR. FLAME M. SCHMIDT

10 GREEN ST., CHARLOTTE, N.C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 00008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00008

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Maryland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>300 Willowbrook Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Maryland 02</u> d. STREET ADDRESS <u>300 Willowbrook Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Moses</u> Middle <u>Sylvester</u> Last <u>Bennett</u>			<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>31</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/23/1917</u>	<b>9. AGE</b> (In years last birthday) <u>44</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Kelly Sp. Tire Co.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Reeses Mill, W. Va.</u>			
<b>13. FATHER'S NAME</b> <u>Phillip Bennett</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Bennett</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>W. W. II 217-10-5403</u>		<b>17. INFORMANT</b> <u>Woodrow Bennett, Golden Lane, Cumberland, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT OF CHEST</u> DUE TO (b) <u>981X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>981X</u> DUE TO (c) <u>981X</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>SUDDEN</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <u>19</u> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURES</b> <u>Benedict Skitarelic</u> M.D.			<b>DATE SIGNED</b> <u>January 31, 1962</u>				
<b>EXAMINER'S NAME (Type)</b> <u>BENEDICT SKITARELIC, M.D.</u>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>R9 Cumberland, Md.</u>				
<b>22a. BURIAL, CREMATION, or other disposal</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Feb 3, 1962</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset Memorial Park near Cumberland Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Hofer</u>		<b>ADDRESS</b> <u>Cumberland Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE FEB 6 '62</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4, to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00009 CERTIFICATE OF DEATH 00009												
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>59 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>				d. STREET ADDRESS <b>147 BEDFORD ST.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>IVY</b>			First <b>IVY</b> Middle <b>M.</b> Last <b>BIBLE</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>15</b> Year <b>19 62</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 5, 1880</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>WILL BROOKS (DECEASED)</b>						14. MOTHER'S MAIDEN NAME <b>Rebecca, A. Flagg (Deceased)</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-05-6128</b>		17. INFORMANT <b>PATIENTS CHART</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive thrombophlebitis of vena cava</b> DUE TO <b>450</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Generalized atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>59 days</b>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> 19 <b>62</b> to <b>1/15</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1/14</b> 19 <b>62</b> , and that death occurred at <b>2:17 A.M.</b> from the causes and on the date stated above.												
22a. SIGNATURE <b>S. G. Weisman</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>GREENE ST., CUMBERLAND, MD.</b>						
22c. PHYSICIAN'S NAME <b>SAVILLE G. WEISMAN, M.D.</b>						22b. DATE SIGNED <b>1/15/62</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>1/17/62</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunset memo. Park</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>						ADDRESS <b>Cumb. Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 18 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00010

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Cumberland.</b>				c. LENGTH OF STAY IN lb <b>X Rt. # 1 Cumberland.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bowmans Addition</b>				d. STREET ADDRESS <b>Bowmans Addition</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Adam</b>		First <b>Henry</b>		Middle <b>Bloss</b>		Last <b>Jan. 27, 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16, 1880</b>	
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Brakeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>			
11. BIRTHPLACE (State or foreign country) <b>North Branch, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Stephan A. Bloss</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Knippenberg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>705-07-9747A</b>			
17. INFORMANT <b>Mrs. Arzeltha M. Bloss</b>				Address <b>Rt. # 1 Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>CORONARY SCLEROSIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>January 28, 1962 R B 9 Cumberland</b> DATE SIGNED EXAMINER'S SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Mem. Gardens</b>		22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	



Charles E. George, Commander, U.S.A.

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Chief of Police

*James M. [illegible]*

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TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 1b Film G305 1/18/62 mh

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE / Cumberland</b> c. LENGTH OF STAY IN lb <b>15 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b> d. STREET ADDRESS <b>Old Row</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALMA N BRATLER</b>		4. DATE OF DEATH Month Day Year <b>JAN 10 19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/09</b>
9. AGE (in years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 19 62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cumb. Blouse Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blouses</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Zablan M &amp;</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELIAS WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hoontz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>CHART</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarction, LCC</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Embolus</b> DUE TO (c) <b>Myocardial Infarction - Coronary Occlusion - CARDIAC Arteriosclerosis Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>15 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1962</b> to <b>Jan 10, 1962</b> ; that (I) (we) last saw the deceased alive on <b>Jan 10, 1962</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Bluesman</b>		22b. DATE SIGNED <b>1/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>		22d. ADDRESS <b>59 GREENE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Patricks Cem</b>		23d. LOCATION (City, town or county) (State) <b>Mt Savage Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
ADDRESS <b>Cumberland Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>RT #1, BOX 503, BOWMAN'S ADD.</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES A. BRIDGES</b>		4. DATE OF DEATH <b>JAN. 23 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/91</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>IRONWORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BRIDGES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET BARTELOW</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>275 07 6701</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>massive cerebral hemorrhage</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1962</b> to <b>Jan 25, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 24, 1962</b> and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clayton L. Durrett</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>DR. DURRETT</b>		22d. ADDRESS <b>1/24/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 26, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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*[Faint, illegible handwritten text, possibly a signature or address, spanning several lines.]*

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 18-20 Film 305 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

00013

Item 8 Film G305 1/11/62 iwk

00013

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>501 OLDTOWN ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE A BRINKER</b>		4. DATE OF DEATH <b>JAN 4 19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1873 1879</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Mathias Brinker</b>		14. MOTHER'S MAIDEN NAME <b>Louise Ruppenkamp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-50-8347</b>	
17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. <b>Myocarditis &amp; Deconformation</b> <b>1 Fluid in lungs / 1440 / 1440</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>3 m</b> <b>9/10/44/5</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left hip - 9 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner) <b>Not Cause</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from chair at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Dec. 23 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 26, 1961</b> to <b>Jan 4, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 4, 1962</b> , and that death occurred at <b>Jan 4, 1962</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>		22d. ADDRESS <b>Cumberland, Md.</b>	
22b. DATE THEREOF <b>DR. DURRETT</b>		22e. DATE <b>1/5/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>I-8-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Patrick Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 8 '62</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00013

00013

1

*Handwritten notes:*  
The first part of the document is a list of names and dates. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list appears to be a record of some kind, possibly a list of births or deaths.

*Handwritten notes:*  
The second part of the document is a list of names and dates. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list appears to be a record of some kind, possibly a list of births or deaths.

*Handwritten notes:*  
The third part of the document is a list of names and dates. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list appears to be a record of some kind, possibly a list of births or deaths.

## MEDICAL CERTIFICATION



1

2

2



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

13  
FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00015													
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1 Cumberland,</u> d. STREET ADDRESS <u>Bowmans Addition</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS EDWARD BROWN</u>				4. DATE OF DEATH Month Day Year <u>Jan. 2, 1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1904</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. Rwy.</u>				11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thomas E. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Grace Hansel</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John Miltenberger Ridgeley, W. Va.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Rt. # 9 Cumberland, Md.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/4/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Mem. Gardens</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland, Md.</u>					
23. FUNERAL DIRECTOR ADDRESS <u>Charles L. George Cumberland, Md.</u>						24a. REC'D BY REGISTRAR <u>JAN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					



Charles L. George Chamberlain, Jr.

1/1/51

Residence, 1234 1/2 St.

Postman on, please call

1/1/51

1/1/51

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00016					00016						
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>24 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			d. STREET ADDRESS <b>418 PACA STREET</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>TILLIE BROWN</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>30</b> Year <b>1962</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 12, 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ANTHONY KNOCH</b>					14. MOTHER'S MAIDEN NAME <b>MARGARET METZGER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>4-22-62</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>—</b>										INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>12:55 AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Allegany Md</b>		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>1/30/62</b> , 19... that (I) (we) last saw the deceased alive on <b>1/29/62</b> , 19..., and that death occurred at <b>12:55 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>					22b. DATE SIGNED <b>1/31/62</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				
22d. ADDRESS <b>122 SO. CENTRE ST., CUMBERLAND, MD.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>					
24 FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>					25a. REG'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>				

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ALLEGANY

WYLYING

ALLEGANY

CUMBERLAND

24 DAYS

CUMBERLAND

118 BACK STREET

TEMPORAL HOSPITAL  
NEW YORK 210 CHILL AVENUE

05

JANUARY 22

BROWN

TITLE

MARCH 12, 1892

WHITE

U.S.A.

CUMBERLAND, WYLYING

AND ROAD

MARGARET METZGER

ANTHONY W. COCHRAN

TEMPORAL HOSPITAL, CUMBERLAND, MD.

1892

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*[Faint, illegible handwritten text, possibly a signature or address, spanning the middle section of the document.]*

122 SO. CENTRE ST., CUMBERLAND, MD.

DR. R. J. WILLIAMS

*[Faint, illegible text at the bottom of the page, possibly a footer or additional address.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00017

## CERTIFICATE OF DEATH

00017

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 Months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>710 Maryland Avenue</b>		d. STREET ADDRESS <b>710 Maryland Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Frances Elizabeth Butler</b>		4. DATE OF DEATH <b>January 8 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 20, 1875</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR <b>8</b> Months <b>19</b> Days <b>62</b> Hours <b>62</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Haldeman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Farrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Mary M. Wright</b>		Address <b>710 Maryland Avenue, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, chr., degenerative</b> DUE TO <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Senility</b> DUE TO <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1940</b> , 19 <b>1-8</b> , to <b>1-8</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1-8</b> , 19 <b>62</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.B. Mathews</b>		22b. DATE SIGNED <b>1-9-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.B. Mathews M.D.</b>		22d. ADDRESS <b>49 Green St, Cumberland, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/11/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
ADDRESS <b>Cumberland Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

000017

CERTIFICATE OF DEATH

000017

M

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
BOSTON, MASSACHUSETTS  
JANUARY 1, 1900

Attest my hand and the seal of the Department of Health, this 1st day of January, 1900.

JOHN A. ALLICE, Registrar General

TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00018

## CERTIFICATE OF DEATH

Item 9 Film 8305 1/29/62 iwk

00018

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>9 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>213 W. SECOND ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PHILLIP</b>		First		Middle		Last		4. DATE OF DEATH <b>JAN. 17 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 17, 1887</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED RAILROAD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ITALY - ROME</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-12-2176</b>		17. INFORMANT <b>PATIENT'S CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 293X DUE TO <b>Myocarditis &amp; Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Asiatic Cholera</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3 mos</b> <b>5 yrs</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Jan. 3, 1962 to Jan. 17, 1962</b>		(County) <b>ALLEGANY</b>	
20g. (State) <b>Md.</b>		21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16, 1962</b> to <b>Jan. 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 16, 1962</b> , and that death occurred at <b>8:40 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durrett</b>				M.D. <b>Clay E. Durrett, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clay E. Durrett, M.D.</b>				22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 20, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Clayton S. Kline</b>	

310013

2 DAYS

OFFICE OF THE DISTRICT CLERK

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10/10/10

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10/10/10

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10/10/10

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

00019

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00019

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>1/6/1962</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b> d. STREET ADDRESS <b>1 502 Washington Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter C. Capper</b>		4. DATE OF DEATH <b>January 21, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/1885</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Lawyer</b>		9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles M. Capper</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Fletcher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>P.O.Box 599</b>	
17. INFORMANT <b>Allegany County Infirmary records.</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, degeneration, Senile</b> DUE TO (b) <b>Arterio-Sclerosis, Cerebral</b> DUE TO (c) <b>deterioration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/6/1962</b> to <b>1/21/1962</b> , that (I) (we) last saw the deceased alive on <b>1/21/1962</b> at <b>11:10 P.M.</b> , and that death occurred at <b>11:10 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>1/22/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 24 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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Allegany

(M)

Comberland

1/6/1962

Allegany County Infirmary

Allegany

Comberland

502 Washington Street

Writer

Editor

January 21, 1962

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White

1/25/1962

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Resident; Lawyer

Virginia

U. S. A.

Charles W. Gappert

Nancy K. Gappert

P.O. Box 299

Comberland, Md.

Allegany County Infirmary, Grafton, W. Va.

1/21/1962

1/6/1962  
11:10 P.M.

1/21/1962

Dr. Lee B. Mathews

19 Greene St., Comberland, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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00020

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLARENCE R. CARTER</b>				4. DATE OF DEATH <b>1 10 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-22-97</b>	
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Builder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Springfield</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOHN CARTER</b>				14. MOTHER'S MAIDEN NAME <b>Elizbeth Delaney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-09-7347</b>			
17. INFORMANT <b>Hoffman, Md.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3</b> to <b>1-10</b> , that (I) (we) last saw the deceased alive on <b>1-10</b> , and that death occurred at <b>821 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>L. BRINGS, M.D.</b>				22d. ADDRESS <b>57 GREENE ST. Cumberland Maryland</b>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-13-62</b>		23c. NAME OF CEMETERY OR PLACE OF BURIAL <b>St. Michaels</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg, Maryland</b>	
24a. FUNERAL HOME OR PLACE OF INTERMENT <b>Pearl Mattingly</b>				24b. ADDRESS <b>26 E. Main Frostburg, Md</b>			
25a. REC'D BY REGISTRAR <b>Jan 16 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL HOME: This certificate must be filled out by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ECKHART</b>		c. LENGTH OF STAY IN 1b <b>LIFETIME</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ECKHART</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>M.</b> Last <b>CARTER</b>				<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>2ND</b> Year <b>19 62</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>MAY 15TH, 1890</b>	<b>9. AGE (In years last birthday)</b> <b>71 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>2</b>	<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>62</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RET. MAGISTRATE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>POLICE COURT</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>ECKHART</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>JAMES CARTER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>HARRIET PORTER</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>217-14-4872</b>		<b>17. INFORMANT</b> Address <b>MRS. ELIZA W. CARTER, ECKHART, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO (b) <b>2 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Frostburg, MD.</b>		<b>(County)</b> <b>ALLEGANY</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 26, 1961</b> <b>to Jan 2, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Jan 2, 1962</b> <b>and that death occurred at</b> <b>1:30 P.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>W. O. McLane</b>				<b>22b. DATE SIGNED</b> <b>Jan 3 1962</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>W. O. McLane,</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>1-5-1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>PORTER CEMETERY</b>		<b>23d. LOCATION (City, town or county)</b> <b>ECKHART, MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>L. R. Durst</b>				<b>25a. REC'D BY REGISTRAR</b> DATE <b>JAN 4 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>	
<b>ADDRESS</b> <b>FROSTBURG, MD.</b>							

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FOR STATE  
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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00022

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>		d. STREET ADDRESS <b>27 UHL STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>27 UHL STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEO V. CHAMBERS</b>				4. DATE OF DEATH <b>JANUARY 26, 1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 28, 1889</b>		9. AGE (in years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN B. CHAMBERS</b>				14. MOTHER'S MAIDEN NAME <b>MARY B. McALLISTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.1 215-20-5306</b>		17. INFORMANT <b>EUGENE CHAMBERS, 35 ALLEN AVENUE, WOODSTOWN, N. J.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> (c) <b>420.1</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W O McLane</b>		M.D. <b>W O McLane MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-27-62</b>	
EXAMINER'S NAME (Type) <b>W O McLane MD</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <b>Frostburg Md</b>		MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-29-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>FROSTBURG, MD.</b>	
23. FUNERAL DIRECTOR <b>J. R. Durrant</b>				ADDRESS <b>FROSTBURG, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. R. Durrant</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate may be retained for not more than 72 hours after death. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician or attending physician, or attending physician, may be retained by the family or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00023

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>45yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland 02</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>606 Maryland Ave.</b>				d. STREET ADDRESS <b>606 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b> Middle <b>M.</b> Last <b>Charlton</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 23, 1872</b>	
9. AGE (In years lost birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Moorefield, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Boswell</b>				14. MOTHER'S MAIDEN NAME <b>Anna Whetzel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Jack Corbett, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>uraemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocarditis &amp; Sanguinaria</b> DUE TO <b>1 yr</b> (c) <b>Arteriosclerosis</b> DUE TO <b>5 yr</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>mar 1961</b> to <b>Jan 25, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 21 1962</b> and that death occurred at <b>11:46/62</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durrett</b>				22b. DATE <b>1/26/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>	
22d. ADDRESS <b>236 Virginia Ave. Cumberland, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 28, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Moorefield, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 29 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

10053

CERTIFICATE OF DEATH

10053

M



1



13  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00024

00024

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>547 N. Centre St.</b>			
3. NAME OF DECEASED (Type or print) <b>Evelyn Marie Clark</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1896</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Franklin, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John R. Sharretts</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Howarth</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Mrs. Albert May Cresaptown, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (a), stating the underlying cause last. (c) <b>ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>JANUARY 21, 1961</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Jan. 24, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		
22d. LOCATION (City, town, or country) (State) <b>Cumberland, Maryland</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				
23. FUNERAL DIRECTOR <b>Louis Stone Inc.</b>			ADDRESS <b>117 Frederick St. Cumb., Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 24 '62</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00025

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00025

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>4 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>1 511 Dilley Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Ellen Clark</u>				4. DATE OF DEATH Month Day Year <u>January 14 19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 16, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTH PLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Petenbrink (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Mary Everline (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-14-7580</u>		17. INFORMANT <u>Mrs. E. M. Horchler</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHRONIC GLOMERULAR NEPHRITIS</u> (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town)		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				DATE SIGNED <u>January 14, 1962</u>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Arthur S. Kraus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Titen please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00026											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL*** RIDGELEY</b>				85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>REBECCA J. COLMER</b>			First Middle Last			4. DATE OF DEATH <b>JAN. 23 19 62</b>			Month Day Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/6/1878</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ACCIDENT-GARRETT CO. - MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HUTZELL</b>						14. MOTHER'S MAIDEN NAME <b>SARAH BURKHOLDER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Eare E. Colmer Rt 1, Ridgeley, W. Va.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Infarction</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis, General</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b> <b>Arteriosclerosis Rt 1</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> , 19 <b>62</b> , to <b>1/23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> , 19 <b>62</b> , and that death occurred at <b>11:19</b> A.M., from the causes and on the date stated above. 22a. SIGNATURE <b>S. G. Weisman</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN, M.D.</b> 22d. ADDRESS <b>59 Green St Cumberland, Md</b> 22b. DATE SIGNED <b>1/23/62</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-26-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SALISBURY F.O.D.F.</b>				23d. LOCATION (City, town or county) (State) <b>SALISBURY - SOMERSET CO. - PA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stanley M Thomas, Salisbury, Pa</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>			

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TESTIMONY OF

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11 - 24 - 1918

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3 & 13 Film G307 2/19/62 iwr

00027

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Little Orleans</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Little Orleans Md</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>Home</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Conrad</b>		4. DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.14 1938</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Bedford County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Conrad</b>		14. MOTHER'S MAIDEN NAME <b>Gladys O. Neal</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Norma M Conrad Little Orleans Md.</b>	
17. INFORMANT <b>Conrad</b>		Address <b>Norma M Conrad Little Orleans Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>835X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Compression of chest</b> (c) DUE TO (e), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>10-15 MIN.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.) <b>Auto slipped off Jack pinning victim underneath.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 p.m. Jan 27 19 62</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Bedford County Allegany Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2.1.62</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Pine Grove</b>		22d. LOCATION (City, town, or country) (State) <b>Monrow Township Bedford Penn.</b>	
23. FUNERAL DIRECTOR <b>Howard F. Stone</b>		24e. REC'D BY REGISTRAR <b>JAN 30 '62</b>	
ADDRESS <b>Hancock Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

MEDICAL CERTIFICATION

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1-1-1917  
1-1-1917



*Copy of letter  
concerning if that*

*But signed off Jack...  
see for 27-12-17*

*Revised letter  
see for 27-12-17*

*1-1-1917  
1-1-1917*

TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00028		Item 1d Film G305		1/18/62		00028			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Died in car before being admitted to Miners Hospital.</b>					d. STREET ADDRESS <b>West Main Street</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>George Daley</b>					4. DATE OF DEATH <b>January 11 1962</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>January 23, 1881</b>				
9. AGE (In years last birthday) <b>80</b> yrs.					10. IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>England</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>216-05-5910</b>				
17. INFORMANT <b>Mrs. Isabelle Winters</b>					Address <b>Lonaconing, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic CV disease class III</b> DUE TO (c) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Mos.</b> <b>Years</b> <b>Years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1956</b> , to <b>January 11, 1962</b> , that (I) (we) last saw the deceased alive on <b>January 9, 1962</b> , and that death occurred at <b>11:30 P.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Leslie R. Miles, Jr., M.D.</b>					22b. DATE SIGNED <b>1-12-62</b>				
22c. PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, Jr., M.D.</b>					22d. ADDRESS <b>Lonaconing, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>1/1/14</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>					23d. LOCATION (City, town or county) (State) <b>Lonaconing, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>					24b. REC'D BY REGISTRAR <b>JAN 15 '62</b>				
ADDRESS <b>Lonaconing, Md.</b>					25b. REGISTRAR'S SIGNATURE <b>Charles S. Huns</b>				

(M)

70023

Allegany

George

George

White

None

Unknown

210-02-2910 Mrs. Leslie Miners

Daughter

Unknown

210-02-2910 Mrs. Leslie Miners

Daughter

Allegany

Allegany

Allegany

George

January 11

1902

January 23, 1901

England

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00029

00029

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westernport</b>		c. LENGTH OF STAY IN lb <b>19yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Westernport</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1 Mi N.W. Westernport</b>				d. STREET ADDRESS <b>1 Mi. N.W. Westernport</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b> First Middle Last				4. DATE OF DEATH <b>Jan. 25 1962</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 1873</b>	
9. AGE (In years last birthday) <b>88 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Grant Ct. W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Schell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cosner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clara Wilson-Westernport, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the large Bowel</b> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 1957</b> to <b>Jan 25 1962</b> , that (I) (we) last saw the deceased alive on <b>1-25-1962</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William W. Lesh</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William W Lesh</b>				22d. ADDRESS <b>Westernport, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/28/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lahmansville</b>		23d. LOCATION (City, town or county) (State) <b>Lahmansville W.Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E.L. Boal</b> ADDRESS <b>Westernport, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		25b. REGISTRAR'S SIGNATURE <b>E. Hines</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00030

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>1 633 Elm Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>633 Elm Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Austin Davis</u>				4. DATE OF DEATH Month Day Year <u>January 15 19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/1889</u>	
9. AGE (In years last birthday) <u>72rs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City Street Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Williams Road, Cumberland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jesse Davis</u>				14. MOTHER'S MAIDEN NAME <u>Ella Jeffries</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W.W. 1</u>				16. SOCIAL SECURITY NO. <u>220-10-2446</u>		17. INFORMANT <u>Edna Schell Davis 633 Elm Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> -----			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>January 16, 1962</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Herman Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR <u>John J. Hafer</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 '62</u>			
ADDRESS <u>Cumberland, Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

10/10/11

0800

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00031  
00031

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLERSLIE, MARYLAND</b>			
c. LENGTH OF STAY IN Ib <b>1 DAY</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN E DE VORE</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>1962</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 2, 1876</b>	
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>KELLY SPRINGFIELD TIRE CO.</b>			
13. FATHER'S NAME <b>JOHN DE VORE</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA WITT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				Address <b>MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation sec. to</b> <b>420.0</b> DUE TO <b>Arteriosclerosis Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Bronchial Asthma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/5/62</b> to <b>1/6/62</b> , that (I) (we) last saw the deceased alive on <b>11/5/62</b> , and that death occurred at <b>2:35 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. GEORGE M. SIMONS</b>				22b. DATE SIGNED <b>1/6/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE M. SIMONS</b>				22d. ADDRESS <b>ALGONQUIN HOTEL - CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 9, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hyndman, Pa. RD#1</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Lutzler</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 11 '62</b>			
ADDRESS <b>Hyndman, Pa.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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ALLIANCE

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1 DAY

ELLSBURY, WYLAND

MEMORIAL HOSPITAL

JOHN

DE WOLF

JANUARY

WHITE

WYLAND, ILL.

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RETIRED

WELLY SPRINGFIELD TIRE CO.

BARBARA WITT

JOHN DE WOLF

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MARYLAND

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. GEORGE W. STONE

JOHN J. LEE, FORT & COMPANY

MEMORIAL HOSPITAL - CUMBERLAND, MD.



(M)

00032

Allegany

Cumberland

Allegany County Jail

Clara

Virginia

Dick

January 26, 1962

Female White

9/13/1964

77

Housewife

Virginia

U. S. A.

Charles Edward Ritter

Laura Virginia Scott

P.O. Box 299

Allegany County Jail records.

1/25/62

1/25/62

1/25/62

Dr. Lee E. Matthews

Dr. Lee E. Matthews  
1/25/62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>350 'A' Street</u>						d. STREET ADDRESS <u>350 'A' Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis J. Dressman</u>						4. DATE OF DEATH <u>Jan 9, 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 14 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cash Valley La Vale</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Dressman</u>						14. MOTHER'S MAIDEN NAME <u>Mary Detterman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-30-0708A</u>		17. INFORMATION <u>Frederick Dressman La Vale Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Acute coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic &amp; Rheumatic Heart Disease with cardiomegaly and chronic congestive failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Rheumatoid arthritis</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> <u>years.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>La Vale</u>		(County) <u>Allegany</u>		(State) <u>Md.</u>	
21. I certify that (I) <u>Wyand F. Doerner, Jr.</u> attended the deceased from <u>March 30, 1960</u> to <u>Jan. 9, 1962</u> , that (I) <u>Wyand F. Doerner, Jr.</u> last saw the deceased alive on <u>January 9, 1962</u> , and that death occurred at <u>La Vale Md.</u> from the causes and on the date stated above.											
22. SIGNATURE <u>Wyand F. Doerner, Jr.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-12-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>						22d. ADDRESS <u>414 N. Mechanic Street, Cumberland, Md.</u>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter + Paul Cem</u>		23d. LOCATION (City, town or county) <u>Cumberland, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>						ADDRESS <u>Cumberland Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

6300

M

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00034

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>66 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>315 Springdale St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>306 Springdale St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>B.</b> Last <b>Durbin</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1895</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	IF UNDER 24 HRS. Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Gaithersburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Durbin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Norris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>705-05-77</b>		17. INFORMANT <b>Carl Ray Durbin, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis</b> (a), stating the underlying cause last. (c) <b>Sudden</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Jan. 25, 1962</b> Address (Street, city, town, or county) <b>R9 Cumberland, Md.</b>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>Benedict Skitarelic, M.D.</b>					
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>Jan. 28, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oldtown, Md.</b>			
23. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. House</b>	

VS. AISME

SM 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be signed by the hospital or attending physician. Page 4 of this certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00035

00035

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <div align="right">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>3/1/1960</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
		f. STREET ADDRESS <b>80 Grant Street</b>	
3. NAME OF DECEASED (Type or print) <b>Hattie Elliott</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> , Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b>	11. IF UNDER 24 HRS. Hours <b>85</b> Min. <b>85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Johnstown, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Henry Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Carry Gollipher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
<b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Virus - Bilateral</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis, Ch. degenerative</b> DUE TO (c) <b>Arterio Sclerosis &amp; Cerebral deterioration</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/1/1960</b> to <b>1/20/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>1/19/62</b> , 19....., and that death occurred <b>@ 6:45 A.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>		22b. DATE SIGNED <b>1/20/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-22-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>M. E. Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Mt. Savage, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Burst</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

(M)

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Allegany

00035  
Allegany

3/1/1960

Frederick

Camden

Allegany County Jail

80 Grant Street

Hattie

Elliot

January

20, 62

Female White

X

12/15/1976

82

Honolulu

Johnstown, Pennsylvania

U. S. A.

George Henry Fisher

Harry Goldfinger

P.O. Box 599

Allegany County Jail records

1/1/62

3/1/1960  
A.M.

1/15/62

Dr. Lee R. Matthews

1/20/62  
X X X  
19 Greene St., Cumberland, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00036

1  
FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>62 Cumberland,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Algonquin Hotel, Washington St.,</b>				d. STREET ADDRESS <b>Algonquin Hotel, Washington St.,</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES HARRISON FISHER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1888</b>	
9. AGE (in years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b>		IF UNDER 24 HRS. Hours <b>73</b> Min. <b>73</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Brakeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy./ Bedford Co. Penna.</b>			
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Thomas E. Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Stuby</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>705-09-4190</b>			
17. INFORMANT <b>Mrs. Cora Ronald</b>				Address <b>1323 Tyndal Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Rt. # 9 Cumberland,</b>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>		DATE SIGNED <b>1/1/62</b>		Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/3/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Madley Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Madley, Penna.</b>	
23. FUNERAL DIRECTOR <b>H. Wayne George</b>				24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b> <b>Cumberland, Md.</b> <b>DAJAN 4 '62</b> <b>Anthony S. K...</b>			



TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be completed by the hospital or attending physician. Page 5 is to be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00037 CERTIFICATE OF DEATH 00037

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN lb <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>PA.</b> b. COUNTY <b>BEDFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEDFORD</b> d. STREET ADDRESS <b>125 1/2 EAST PITT ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAULINE</b> First Middle Last <b>FRANCHI</b>		4. DATE OF DEATH <b>JAN 8, 1962</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1888</b> 9. AGE (In years last birthday) <b>73 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. PLACE (County & State, or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alemando MECONI</b>		14. MOTHER'S MAIDEN NAME <b>Giovanna ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Lino J. Franchi</b>		Address <b>Bedford, Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> 434-4 DUE TO (b) <b>Myocardial fibrosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>Coronary arteriosclerosis</b> <b>CARDIAC DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/8 1962</b> to <b>1/8 1962</b> that (I) (we) last saw the deceased alive on <b>1/8 1962</b> , and that death occurred <b>10:45 P</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Jacobson</i> M.D.		22b. DATE SIGNED <b>1/10/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JACOBSON</b>		22d. ADDRESS <b>50 PERSHING ST. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/12/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		25a. REC'D BY REGISTRAR <b>JAN 12 '62</b> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00038 CERTIFICATE OF DEATH 00038											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>				c. LENGTH OF STAY IN 1b <b>71 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westernport</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucy May Green</b>			First Middle Last			4. DATE OF DEATH <b>Jan. 17 19 62</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 20, 1890</b>		9. AGE (In years last birthday) <b>70 7</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Garrett-MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Dennis Grove</b>						14. MOTHER'S MAIDEN NAME <b>Matilda Clark</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank Green-R.D. 1-Westernport, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic</b> <b>42 2002</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>5 Years</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1957</b> to <b>Jan. 17, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 9, 1962</b> , and that death occurred at <b>6:38 A</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Paul R. Wilson</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>						22d. ADDRESS <b>Piedmont, W. Va.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town or county) <b>Westernport</b>			23e. (State) <b>Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Eliz Boal</b> Westernport, Md.						25a. REC'D BY REGISTRAR DATE <b>JAN 22 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00039

CERTIFICATE OF DEATH

Reg. Dist. No.

00039

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <del>SOMERSET</del> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG, MD</u>		c. LENGTH OF STAY IN 1b <u>3 HRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINORS Hosp, Frostburg, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE, MD</u> d. STREET ADDRESS <u>11X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE ELIZABETH HANET</u>		4. DATE OF DEATH Month Day Year <u>JAN. 12 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 27 1897</u>
9. AGE (In years last birthday) yrs. <u>64</u>		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ST PAUL SOMERSET Co, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS SMARMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY MARGARET OPEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Adam Hamft Grantsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>59</u> , to <u>1-12</u> , 19 <u>62</u> that I last saw the deceased alive on <u>1-12</u> , 19 <u>62</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>39 W. Main St. 1/12/62</u>	
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/15/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE GARRETT Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

10032

W. J. Smith

DECEASED

W. J. Smith, of the County of ... State of ...

was born ...

... died ...

... cause of death ...

... signed ...

... at ...

... in the presence of ...

... and ...

... at ...

... on ...

... at ...

... by ...

... in the presence of ...

... at ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00040

00040

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>52 Cumberland Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>1 457 William St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Carleton W.</u> Middle <u>Hanks</u> Last <u>Hanks</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>10</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 10, 1898</u>		<b>9. AGE</b> (In years and birthday) <u>63</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life (even if retired)) <u>Pharmacist Owner</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pharmacist</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cumberland Md</u>	
<b>13. FATHER'S NAME</b> <u>Nyesses Grant Hanks</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Dawson</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war and service) <u>WWI</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-05-4017</u>			
<b>17. INFORMANT</b> <u>Mrs. Bessie Hanks</u>				<b>18. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-10-62</u> , <b>19</b> <u>62</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1-10-62</u> , <b>19</b> <u>62</u> , <b>and that death occurred at</b> <u>12:35P</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>W.A. Williams M.D.</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1-11-62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>  </u>				<b>22d. ADDRESS</b> <u>Cumberland, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/13/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset memo. Pk</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Cumberland Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Louis Stein Inc.</u>				<b>ADDRESS</b> <u>Cumb. Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>				<b>DATE</b> <u>JAN 15 '62</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>  </u>	

0502

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00041

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY in 1b <u>12 Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>127 Columbia Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>127 Columbia Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nettie</u> <u>Hartsock</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>22</u> <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 28, 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Bucy (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Stacia Shaw (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Marshall L. Hartsock</u>				Address <u>127 Columbia Street, Cumberland, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u> 421 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CALCIFIC AORTIC STENOSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>JANUARY 22, 1962</u> DATE SIGNED Address (Street, city, town, or county) <u>R9. Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		24a. REC'D BY REGISTRAR <u>JAN 25 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00042

## CERTIFICATE OF DEATH

00042

Item 3, Film G-307 2/15/62. cac.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegheny</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>515 Riehl Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>515 Riehl Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Regina</u> <sup>First</sup> <u>Wilhelmina</u> <sup>Last</sup> <u>Helmstetter</u> Also known as <u>Mamie R. Middle Helmstetter</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>18,</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 23 1890</u>	
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cash Valley, P. I. Cumberland Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>George Helmstetter</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Sabina Roehrig</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>			
<b>16. SOCIAL SECURITY NO.</b> <u>  </u>				<b>17. INFORMANT</b> <u>Mrs. Louis Madden</u> Address <u>515 Riehl Ave. Comb. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile arteriosclerosis &amp; anemia &amp; osteoporosis of the spine</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Dec 1, 1961</u> to <u>Jan 18, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 4, 1962</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>B. M. Rhindler</u> <b>M.D.</b>				<b>22b. DATE SIGNED</b> <u>1/20/62</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>				<b>22d. ADDRESS</b> <u>  </u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Jan. 22, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter &amp; Paul Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Cumberland</u> <b>(State)</b> <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Louis Stein, Inc.</u> <b>ADDRESS</b> <u>117 Fredenckst. Cumberland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>DATE</b> <u>JAN 22 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00043

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00043

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLOTHIAN</b>			c. LENGTH OF STAY IN 1b <b>4 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLOTHIAN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>R.</b> Last <b>HENDERSHOT</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>24</b> Year <b>1962</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 29, 1881</b>		
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB HENDERSHOT</b>				14. MOTHER'S MAIDEN NAME <b>WIGFIELD</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>CHAS. HENDERSHOT, ARTHURDALE, W. VA.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dilatation</b> 422.1 DUE TO <b>Myocardial Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 years</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>W O Mc Lane</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>W O Mc Lane MD asst</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-27-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND, MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. K. Buret</b>				ADDRESS <b>FROSTBURG, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '62</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		DATE SIGNED <b>Jan 24 1962</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to a removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00044											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X MOUNT SAVAGE</b>				d. STREET ADDRESS <b>1 ROUTE #1,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVENUES</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BABY</b> <b>BOY</b> <b>HOLBROOK</b>						4. DATE OF DEATH <b>JANUARY 14, 1962.</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 13, 1962</b>		9. AGE (In years last birthday) <b>23</b> yrs. IF UNDER 1 YEAR Months Days <b>26</b> Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Allen Kendall</b>						14. MOTHER'S MAIDEN NAME <b>FRANCES KAY HOLBROOK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>776 X</b> IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13, 1962</b> to <b>Jan 14, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 14, 1962</b> , and that death occurred at <b>9:05 A.M.</b> on the date stated above. 22a. SIGNATURE <b>W. A. H. Hager</b> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS <b>Cumberland, Md</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1/16/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Palo Alto Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Hyndman, Pa. RD#1</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b> ADDRESS <b>Hyndman, Pa.</b> 25a. REC'D BY REGISTRAR <b>JAN 19 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>											

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CERTIFICATE OF DEATH

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WILLIAM

WILLIAM

WILLIAM

MONTE SAVAGE

1 DAY

CONDEMNED

MEMORIAL HOSPITAL  
1200 L & WINDICK AVENUE

JANUARY 13, 1932

MALE WHITE

COLUMBIA, MO.

THOMAS RAY HOLBROOK

John Allen Holbrook

MEMORIAL HOSPITAL - COLUMBIA, MO.

Y. 1000

1/13/32

W. P. 1000

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00045  
CERTIFICATE OF DEATH  
00045

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG.</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Route 1, FROSTBURG,</b>	
d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>C.</b> Middle <b>MAE</b> Last <b>HOUSE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22ND</b> Year <b>19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6TH, 1885</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOUSEWORK</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN HOUSE</b>		14. MOTHER'S MAIDEN NAME <b>SARAH DENISON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MISS JESSIE HOUSE, RT.1, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Carcinoma Toxic</b> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>undiscovered?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>	
20c. TIME OF INJURY Hour <b>X</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct.</b> 19 <b>61</b> to <b>1/22</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> 19 <b>62</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Martin M. Rothstein M.D.</b>		22b. DATE SIGNED <b>1/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN,</b>		22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-25-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Burt</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 26 '62</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



20042

CERTIFICATE OF DEATH

60002

ALLIANCE

WILLIAM

ALLIANCE

PROSECUTED

4 DAYS

NOV 15, 1955

LYNN HOSPITAL

NOV 15, 1955

LYNN HOSPITAL

NOV 15, 1955

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00046

## CERTIFICATE OF DEATH

00046

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PIEDMONT</b>			
c. LENGTH OF STAY IN 1b <b>15 min</b>				d. STREET ADDRESS <b>67 E. HAMPSHIRE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>84 MAIN STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
<b>RAYMOND</b>		<b>C.</b>		<b>HUDSON</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 22, 1901</b>	9. AGE (In years last birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSURANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AMHERST CO. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARRINGTON O. HUDSON</b>				14. MOTHER'S MAIDEN NAME <b>SAMANTHA GOOCH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>235-32-6913</b>		17. INFORMANT <b>MRS. MILDRED HUDSON, PIEDMONT, W.VA.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> 420 Conditions, if any, which gave rise to immediate cause (b) <b>420</b> (c) <b>420</b> stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>18 Months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1960</b> to <b>Jan 2, 1962</b> that (I) (we) last saw the deceased alive on <b>Dec 29, 1961</b> , and that death occurred at <b>3P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul R. Wilson</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/3/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. PAUL R. WILSON</b>				22d. ADDRESS <b>ASHFIELD ST. PIEDMONT, W.VA.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PHILOS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WESTERNPORT ALLEGANY MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. F. Redlock Jr.</b>				25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Ernest S. Kraus</b>	

TO HOSPITAL OR FUNERAL HOME: This certificate must be filed with the hospital or funeral home within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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18-1-1945

General Sir H. D. G. ...

18-1-1945

18-1-1945

General Sir H. D. G. ...

18-1-1945

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00047

00047

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM DONALD JAMISON</b>				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1962</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-25-13</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>29</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed (ill)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
11. BIRTHPLACE (State or foreign country) <b>Deal, Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Jamison</b>				14. MOTHER'S MAIDEN NAME <b>Susan Knepp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>W.W.No.2 214-07-3992</b>			
17. INFORMANT <b>Frostburg, Md. (Mother)</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>advanced arteriosclerosis</b> (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>26hrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 1958</b> to <b>Jan. 29, 1962</b> that (I) (we) last saw the deceased alive on <b>29 Jan. 1962</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John B. Davis,</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>1/29/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>				22d. ADDRESS <b>23 Broadway Frostburg Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>White Oak Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>White Oak, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Reuben H. Montem</b> ADDRESS <b>23 E. Main, Frostburg, Md.</b>				25. REC'D BY REGISTRAR <b>FEB 5 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00048

00048

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12/22/1961</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>				d. STREET ADDRESS <b>1 60 Boone Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna Catherine Johnson</b>		First Middle Last		4. DATE OF DEATH <b>January 1, 1962</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Anthony Wadasz</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Moffatt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O.Box 599 Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis chr. decompensating</b> <b>422. DUE TO</b> <b>Arterio-sclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Cerebral Thrombosis Cerebral deterioration</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/22/61</b> , 19....., to <b>1-1-62</b> , 19....., that (I) (we) last saw the deceased alive on <b>1-1-62 @ 8:00 A.M.</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Lee B. Mathews</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/1/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 4, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 8 '62</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

Allegany

Cambridge

12/22/51

Cambridge

50 Boone Street

Allegany County Jail

Anna

Caroline

Johnson

January 1,

52

Female White

9/15/1886

75

Honorable

John Jones

Philadelphia,  
Pennsylvania

U. S. A.

William Anthony Weber

Catherine J. Weber

P.O. Box 209 Cambridge, N.Y.

Allegany County Jail records.

12/22/51

1:00 A.M.

Dr. Lee E. Mathews

59 Greene St., Cambridge, N.Y.

1/1/1952

**1**  
**FOR STATE**  
**HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00049

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00049

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Between Res. &amp; Cumb.</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cresaptown,</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Enroute to Cumberland, Hosp.</b>			d. STREET ADDRESS <b>5th Ave., at Main St.,</b>		
3. NAME OF DECEASED (Type or print) <b>MATTIE BELLE KNICK</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>29,</b> Year <b>19 62</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1892</b>		9. AGE (In years last birthday) <b>70</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photo. Lab. Employee Social Security</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lexington, Va.</b>	
13. FATHER'S NAME <b>( Unknown ) Hicks</b>			14. MOTHER'S MAIDEN NAME <b>( Unknown )</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>216-14-1383</b>		
17. INFORMANT <b>Mr. Elbert Knick</b>			Address <b>Cresaptown, Md.</b> <b>5th Ave., @ Main St.,</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland,</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/29/62</b> Rt. # <b>9</b> Cumberland, Md.					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/1/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or country) <b>Cumberland,</b>	(State) <b>Md.</b>
23. FUNERAL DIRECTOR <b>Charles L. George</b>			24a. REC'D BY REGISTRAR DATE <b>FEB 5 '62</b>		
ADDRESS <b>Cumberland, Md.</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



*Handwritten signature*

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Charles A. ...  
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...

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00050

00050

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>Mineral</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b> d. STREET ADDRESS <b>RT#4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>B.</b> Last <b>Kooken</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>3</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-91</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>x</b>	IF UNDER 24 HRS. Hours <b>3</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>W. VA.</b>
13. FATHER'S NAME <b>John Ours (D)</b>		14. MOTHER'S MAIDEN NAME <b>Snyder</b> <b>CHRISTINA (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Pt's Chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Possible acute cholecystitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>62</b> to <b>1-4</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1-4</b> , 19 <b>62</b> , and that death occurred at <b>1-4</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl Paul</b>		22b. DATE SIGNED <b>1-4-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. EARL PAUL</b>		22d. ADDRESS <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Queen's Point</b>		23d. LOCATION (City, town or county) (State) <b>Keyser W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Paul</b>		25a. REC'D BY REGISTRAR <b>Westerport, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		DATE <b>JAN 8 '62</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00051 CERTIFICATE OF DEATH 00051									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>			d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL, INSTITUTION (Name and street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>KYLE</b> Last <b>KYLE</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>18</b> Year <b>1962</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1905</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b>		IF UNDER 24 HRS. Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stewart</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fireman's Club</b>			11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FRANK KYLE</b>					14. MOTHER'S MAIDEN NAME <b>ANNA M. LEE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-01-3750</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma</b> <b>462</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hematemesis</b> <b>Esophageal varices; gastritis; chronic pancreatitis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>7 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1/13/62</b> to <b>1/18/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/18/62</b> 19 <b>62</b> , and that death occurred at <b>9:12 P.M.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>DR. SAMUEL JACOBSON</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL JACOBSON</b>					22d. ADDRESS <b>50 Pershing Street 16 GREENSBORO, CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		23d. LOCATION (City, town or county) (State) <b>Moseow Mills Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Boal - Westernport, Md</b>					25a. REC'D BY REGISTRAR <b>DATE JAN 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

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7 DAYS

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MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

JANUARY 10, 1935

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1-1-1935

WHITE

U. S. A.

BARTON, MD.

ARMY M. 135

FRANK WYLE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

CLINICAL 3750

EMERSON

EMERSON

EMERSON: chronic paronychia

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2:15 P.M.

2:15 P.M.

DR. JACOBSON

DR. JACOBSON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00052

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00052

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural of Cumberland, Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>5 Rose Lawn Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laurie</b> Middle <b>Ann</b> Last <b>Lehman</b>				4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 1, 1956</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>		IF UNDER 24 HRS. Hours <b>5</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David Calvert Lehman</b>				14. MOTHER'S MAIDEN NAME <b>Jean Louise DeVore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>David C. Lehman, 5 Rose Lawn Ave. La Vale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> <b>180X</b> DUE TO <b>ASPIRATION OF STOMACH CONTENTS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15-20 Minutes</b> (c) <b>15-20 Minutes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15-20 Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>WILM'S TUMOR OF RIGHT KIDNEY</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>R 9 Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
OCCUPATION		RESIDENCE	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
POSTMORTEM EXAMINATION		LABORATORY TESTS	
SIGNATURE OF EXAMINER		DATE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00053

00053

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>62 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Nixon</u> Last <u>Linn</u>		4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/88</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia-Keyser</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Linn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Nixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-2554</u>	
17. INFORMANT <u>Mrs. John Linn, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis, chronic degenerative</u> DUE TO (c) <u>Arterio Sclerosis, Sclerotic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 5</u> , 19 <u>62</u> , to <u>Jan. 22</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan. 22</u> , 19 <u>62</u> , and that death occurred at <u>2:10 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Greene St., Cumberland, Md.</u> DATE SIGNED <u>1-23-62</u>			
ACTUAL SIGNATURE <u>L. B. Mathews</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 25, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Slanesville, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 4 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00054													
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>2/1/1958</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>				d. STREET ADDRESS <b>309 Decatur Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Lulu Grace Lowery</b>						4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1962</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>10/26/1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Practical Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Myersdale, Pennsylvania</b>				11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>					
13. FATHER'S NAME <b>David Franklin Geisbert</b>						14. MOTHER'S MAIDEN NAME <b>Isabelle Miller</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>(If yes give year or dates of service)</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, degenerative, Senile</b> <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>arteriosclerosis, degenerative</b> DUE TO (c) <b>Cerebral hemorrhage, left Hemiplegia</b>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2/1/1958</b> , 19....., to <b>1/27/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>1/27/62</b> , 19....., and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Dr. Lee B. Mathews</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/29/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>						22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>JAN. 30, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MEYERSDALE, PA.</b>					
24 FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>						ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Catharine S. Frank</b>			

00054

ALLEGANY COUNTY

00054

Allegany

Maryland

Allegany

Cambridge

2/1/58

Cambridge

309 Beacon Street

Allegany County Infirmary

January 21, 1958

Lowery

Grace

John

10/25/1951

Female White

U. S. A.

Myersdale  
Pennsylvania

Method: Practical Nurse

Isabelle Miller

David Franklin Galsberg

Cambridge, Md.

P.O. Box 299

Allegany County Infirmary Records

1/27/58

2/1/58

1/27/58

1/27/58

X

X

X

19 Greene St., Cambridge, Md.

Dr. Lee E. Henson

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
00055															
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Allegany) Cumberland</b>					c. LENGTH OF STAY IN lb <b>10/26/1960</b>										
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(County) Allegany County Infirmary</b>					d. STREET ADDRESS <b>533 Cumberland Street</b>										
3. NAME OF DECEASED (Type or print) <b>Irene Marie Martin</b>					4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1962</b>										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/24/1893</b>		9. AGE (In years last birthday) <b>69</b> yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
13. FATHER'S NAME <b>Marcellus Martin</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth A. Kelley</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>—</b>					17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy - arteriosclerosis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiovascular disease - hypertension</b> DUE TO (c) <b>arterio-sclerosis (cerebral delineation)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>10/26/60</b> , 19....., to <b>1/1/62</b> , 19....., that (I) (we) last saw the deceased alive on <b>1-1-62</b> , 19....., and that death occurred at.....M, from the causes and on the date stated above.						
22a. SIGNATURE <b>Robert Mathews</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/2/61</b>			22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>					
22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>															
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE THEREOF <b>1/3/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>					ADDRESS <b>Cumb. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hunt</b>						

M

00052

00052

Allegany

Maryland

Allegany

(Allegany) Cumberland 10/26/1950

Cumberland

(County)

Allegany County Jail

533 Cumberland Street

Frank Marie Martin January 1, 1952

Female White 12/21/1953

Housekeeper Cumberland, Maryland U. S. A.

Marcellus Martin

Elizabeth A. Kelly

P.O. Box 200 - Cumberland, Md.  
Allegany County Jail

2:30 10/26/50

1/1/52

1/2/51

12 Greene St., Cumberland, Md.

Dr. Lee B. Newman

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
00056														
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Moscow</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Moscow</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) <b>JOHN</b> <b>McCUTCHEON</b>					4. DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>1962</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/14/1878</b>		9. AGE (In years last birthday) <b>83</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Barton, MD.</b>						
13. FATHER'S NAME <b>Sam McCutcheon</b>					14. MOTHER'S MAIDEN NAME <b>Fannie Jacobs</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs. James McPartland, Lonaconing, MD.</b> (Daughter)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Cardiovascular Disease</b> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>years</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19, 1961</b> , to <b>Jan 27, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 23, 1962</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>[Signature]</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>					22d. ADDRESS <b>LONA CONING MD.</b>									
22b. DATE SIGNED <b>1-27-62</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/29/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Moscow, MD.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>					ADDRESS <b>LONA CONING, MD.</b>									
25a. REC'D BY REGISTRAR <b>JAN 30 '62</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									



20053

Library

10000

10000

JOHN

LOUISIANA

MISSISSIPPI

Life Insurance

Life Insurance

28

25-10-1900

25-10-1900

U.S.A.

25-10-1900

25-10-1900

25-10-1900

(Signature)

Life Insurance

Life Insurance

25-10-1900

25-10-1900

25-10-1900

25-10-1900

25-10-1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00057											
00057											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLAND</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ANNA S. McFARLAND</b>						4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3RD</b> Year <b>19 62</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 4, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL STEVENSON</b>						14. MOTHER'S MAIDEN NAME <b>MARTHA H. CLISE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT <b>MARGARET E. STEVENSON</b>		Address <b>12 E. COLLEGE AV. FROSTBURG, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> 4222 DUE TO (b) <b>Broncho Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 15, 1961</b> to <b>Jan 3, 1962</b> that (I) <b>(u)</b> last saw the deceased alive on <b>Jan 2, 1962</b> and that death occurred at <b>11:35 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W O McLane</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 3 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLANE</b>						22d. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-6-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>ECKHART, MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst</b>						ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

5200

RECEIVED: 31 JULY 1988

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00058

Item 4 Film G305 1/11/62

00058

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>27 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>810 ASHLAND AVE.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>810 ASHLAND AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLA</b> Middle <b>McKINNEY</b> Last <b>McKINNEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 9, 1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY SOLOMAN</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN KING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WALTER A. McKINNEY</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> DUE TO <b>162-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 mo's</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-22-61</b> 19____, to <b>1-2-62</b> 19____, that (I) (we) last saw the deceased alive on <b>1-2-62</b> 19____, and that death occurred at <b>2p</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>1-4-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 6 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILLS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PIQUA, OHIO</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Hume</b>	

1952

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

11115



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 11 Film G306 1/31/62 iwk 00059											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				12. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> COUNTY <b>BEDFORD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE ELIZABETH MILLER</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 22 19 62</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-5-1875</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>USA Penna.</b>			
13. FATHER'S NAME <b>CHARLES SHAFFER</b>				14. MOTHER'S MAIDEN NAME <b>EVELINE WELCH</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>											
DUE TO (b) <b>CEREBRAL CONTUSIONS</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>FRACTURED RIBS, LEFT</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <b>AUTOMOBILE ACCIDENT</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>5:00</b> <b>p.m.</b> <b>Jan. 19 19 62</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>			
				20f. (City or town) <b>Near Hyndman, Bedford, Pa.</b>				(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 22, 1962			
				Address (Street, city, town, or county) <b>R9 Cumberland, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/24/62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>			
				22d. LOCATION (City, town, or country) <b>Hyndman, Bedford Co. Pa.</b>				(State)			
23. FUNERAL DIRECTOR <b>Harvey H. Teigler</b>				ADDRESS <b>Hyndman, Penna.</b>				24a. REC'D BY REGISTRAR <b>JAN 26 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **00060**

00050

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 3mos. 26days. 22</b> <b>Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucille</b> Middle <b>C.</b> Last <b>Haff</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/14/83</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rhodes Smith</b>		14. MOTHER'S MAIDEN NAME <b>Belle Leach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Dr. Lucille Clay, 101 Maple St., (Dght)</b>	
17. INFORMANT <b>Frostburg, Md.</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degenerative senile</b> DUE TO <b>Ch. Brain, Sudden &amp; Psychotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Reaction - 17:11</b> DUE TO <b>Reaction - 17:11</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1961</b> , to <b>Jan. 7, 1962</b> , that I last saw the deceased alive on <b>Jan. 6, 1962</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene Street, Winchester, Kentucky</b> DATE SIGNED <b>1/8/62</b>			
ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D.		DATE SIGNED <b>1/8/62</b>	
PHYSICIAN'S NAME (Type) <b>L. B. Mathews, M.D.</b>		ADDRESS (Street, city or town, state) <b>49 Greene Street, Winchester, Kentucky</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/9/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Winchester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Kentucky</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>25 E. Main, Frostburg, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Carling L. Kenna</b>		DATE <b>JAN 11 '62</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS



1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. CAUSE OF DEATH	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF CHURCH		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF BURIAL PLACE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF SUPERVISOR		27. SIGNATURE OF ASSISTANT SUPERVISOR		28. SIGNATURE OF CLERK		29. SIGNATURE OF RECEPTIONIST		30. SIGNATURE OF TELEPHONE OPERATOR	
31. SIGNATURE OF MAIL ROOM		32. SIGNATURE OF RECORDS SECTION		33. SIGNATURE OF STATISTICS SECTION		34. SIGNATURE OF PUBLIC AFFAIRS SECTION		35. SIGNATURE OF LEGAL COUNSEL		36. SIGNATURE OF CHIEF OF BUREAU	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00061

## CERTIFICATE OF DEATH

Item 7 Film G-306 2/6/62 iwk

00061

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> <b>ALLEGANY</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN lb <b>19 DAYS</b>		d. STREET ADDRESS <b>11 E FIRST STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>C</b> Last <b>O'Connor</b>		4. DATE OF DEATH Month <b>1</b> Day <b>30</b> Year <b>1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>unknown</b>		8. DATE OF BIRTH <b>12/17/89</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>62</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Arlington Neb.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David C. O'Connor</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Shaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>CHART</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> DUE TO (b) <b>myocarditis - Scurvy</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>6 wks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 11, 1962</b> to <b>Jan 30, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 30, 1962</b> and that death occurred at <b>8:40p</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Clayton L. Durrett</b> M.D.		22b. ADDRESS <b>1/31/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR DURRETT</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-2-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>FEB 6 '62</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00062											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Cumberland,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>						d. STREET ADDRESS <b>Upper Homewood Add.</b>					
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>THOMAS</b> Last <b>PLUMMER</b>						4. DATE OF DEATH Month <b>1</b> Day <b>22</b> Year <b>1962</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/9/95</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman,</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rawlings, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis M. Plummer</b>						14. MOTHER'S MAIDEN NAME <b>Eugenia Ullum</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes,</b>						16. SOCIAL SECURITY NO. <b>W.W. # 1</b>		17. INFORMANT <b>Mrs. Catherine M. Plummer Rt. # 1 Cumb.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure (intractable)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old Large Myocardial Infarction of left ventricle</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Absence of left kidney; pyelonephritis of right kidney; cardiac cirrhosis</b>											
19. WAS AUTOPSY PERFORMED? <b>NO</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>November 29, 1961</b> , to <b>January 22, 1962</b> that (I) (we) last saw the deceased alive on <b>January 21, 1962</b> , and that death occurred <b>12:30</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>DR. DOERNER, Wyand F. Jr.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-23-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. DOERNER, Wyand F. Jr.</b>						22d. ADDRESS <b>414 N. Mechanic St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/25/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Mem. Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>						ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Frame</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00063

## CERTIFICATE OF DEATH

00063

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>	
c. LENGTH OF STAY IN lb <b>42 YRS.</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>OLIVER T. PORTER</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>JANUARY 22ND, 19 62</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>FEB. 4th, 1888</b>
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MINE OPERATOR</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>COAL MINING</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>WILLIAM PORTER</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET LANCASTER</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>214-32-3023</b>	
<b>17. INFORMANT</b> <b>Miss Mildred Porter, Barton, Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO (b) <b>acute decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <b>WESTERNPORT,</b>		<b>(County)</b> <b>MD.</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/1/62</b> , <b>19</b> , to <b>1/22/62</b> , <b>19</b> , that (I) (we) last saw the deceased alive on <b>1/22/62</b> , <b>19</b> , and that death occurred <b>1/22/62</b> from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>RAYMOND W. REEVES, M.D.</b>	
<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>RAYMOND W. REEVES,</b>	
<b>22d. ADDRESS</b> <b>WESTERNPORT, MD.</b>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	
<b>23b. DATE THEREOF</b> <b>1-24-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ECKHART CEMETERY</b>	
<b>23d. LOCATION</b> (City, town or county) <b>ECKHART,</b>		<b>(State)</b> <b>MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. P. Frostburg</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 26 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Clifford L. Frostburg</b>		<b>25c. ADDRESS</b> <b>FROSTBURG, MD.</b>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The attending physician and completely filled in the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1/21/61</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			d. STREET ADDRESS <b>1 727 Fayette Street</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>							e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Ella Elizabeth Rafter</b>					4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1962</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/28/1878</b>		9. AGE (In years last birthday) <b>83</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Keyser, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						
13. FATHER'S NAME <b>Samuel Davis</b>					14. MOTHER'S MAIDEN NAME <b>Mary Frances Brown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>					17. INFORMANT <b>P.O. Box 599 Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, degenerative, Sudden</b> <b>443A</b> DUE TO <b>arterio sclerosis &amp; hypertension</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Coronary Heart Disease, Left Hemiplegia</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/21/61</b> to <b>1/22/62</b> , that (I) (we) last saw the deceased alive on <b>1/22/62</b> and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Dr. Lee B. Mathews</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>									
22b. DATE SIGNED <b>1/23/62</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>JAN. 25, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>							
24 FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>					ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. K. K...</b>					

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(1)

Allegany

Allegany

Allegany

Cumberland

1/21/61

Cumberland

Allegany County Infirmary

737 Fayette Street

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Bliss

Elizabeth

Robert

January 22

62

Female

White

X

1/28/1878

83

Houswife

Keyser, West Virginia

U. S. A.

Samuel Davis

Harry Frances Brown

Cumberland, Md.

P.O. Box 222

Allegany County Infirmary records.

1/22/62

1/21/61  
1:20 P.M.

1/22/62

Dr. Lee E. Matthews

49 Greene St., Cumberland, Md.

1/23/62

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00065

00065

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O. A. MINERS HOSPITAL</b>				d. STREET ADDRESS <b>59 TARN TERRACE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET A. RALSTON</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 1, 1962</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 16, 1881</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES M. CONDON</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN RAFFERTY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>212-18-1567B</b>			
17. INFORMANT <b>MRS. VIRGINIA KIGHT, FROSTBURG, MD.</b>				Address <b>59 TARN TERRACE,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Interval between onset and death 2 hours several years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 to <b>Jan 1, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 1, 1962</b> and that death occurred at <b>8:40 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. O. McLane</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 3 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>				22d. ADDRESS <b>E. MAIN ST., FROSTBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 4 '62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Durrst</b>				ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

hours after

the funeral

ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper.

TO HOSPITAL

death. Page 4 m

TO FUNERAL D

director, page 3 s. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, it

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00066

00066

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> <span style="float: right;">b. STATE <u>MARYLAND</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg, Maryland</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>ALLEGANY</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg, Maryland</u> d. STREET ADDRESS <u>82 Beall Street, Extended</u>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>Lashorn</u> Last <u>Redman</u>			<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>28</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Black</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/24/1862</u>		<b>9. AGE</b> (In years last birthday) <u>99</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Petersburg, W. Va.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		
<b>13. FATHER'S NAME</b> <u>John Redman</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah Smith</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mrs. Rosia Kelly, Frostburg, Maryland</u> <span style="float: right;">Address <u>  </u></span>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic Cardiovascular Disease</u>  <b>422.1</b> DUE TO                  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO (b) <u>  </u>  <u>  </u> DUE TO (c) <u>  </u> </td> <td style="width: 20%; vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>3 days</u> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic Cardiovascular Disease</u> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO (b) <u>  </u> <u>  </u> DUE TO (c) <u>  </u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Arteriosclerotic Cardiovascular Disease</u> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO (b) <u>  </u> <u>  </u> DUE TO (c) <u>  </u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u>						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <u>  </u> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>19</u> <u>  </u> <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JUNE, 1960</u> <b>to</b> <u>1/28, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/28, 1962</u> <b>and that death occurred at</b> <u>3:45</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Martin M. Rothstein M.D.</u> <b>22b. DATE SIGNED</b> <u>1/29/62</u>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>MARTIN M. ROTHSTEIN M.D.</u>			<b>22d. ADDRESS</b> <u>48 BROADWAY - FROSTBURG - MD.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/31/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Frostburg Memorial Park</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John F. Hafer</u>		<b>ADDRESS</b> <u>Cumberland, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Hines</u> <b>DATE</b> <u>JAN 31 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>25c. LOCATION (City, town or county)</b> <u>Frostburg</u> (State) <u>MD</u>					

MEDICAL CERTIFICATION

Page 72 hours after

JF

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12/12/12  
John J. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00067											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> COUNTY <b>Bedford</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. LENGTH OF STAY in 1b <b>8 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyndman</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cumberland Memorial Hospital</b>				d. STREET ADDRESS <b>75X-3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>B</b> Last <b>RITCHEY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>1,</b> Year <b>19 62</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1917</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Celanese</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textiles</b>		11. BIRTHPLACE (State or foreign country) <b>Hyndman, Pennsylvania</b>		12. COUNTRY OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Blair Ritchey</b>				14. MOTHER'S MAIDEN NAME <b>Laura Kennedy</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WLL 208-03-7245</b>		17. INFORMANT Address <b>Mrs. William Ritchey Hyndman, Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND OF ABDOMEN</b> DUE TO <b>919.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>8 Days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>ACCIDENTLY SHOT WHILE HUNTING</b>							
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. Dec. 26 1961</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Forest</b>		20f. CITY or town <b>Hyndman, Bedford Co Pa.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>January 1, 1962</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/4/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Hyndman, Bedford Co Penna.</b>			
23. FUNERAL DIRECTOR <b>Harvey H. Ziegler, Hyndman, Penna.</b>						24a. REC'D BY REGISTRAR <b>JAN 3 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thoms</b>			

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101 PIEDMONT AVE.

WARRICK & HORTON

GENERAL HOSPITAL

1 JANUARY

F. ROSE L. EYER

JULIA

SEPTEMBER 23, 1933

X

WHITE

ALLGARY

U. S. A.

PENNSYLVANIA

JULIA A. BOCH

WARRICK THE COLLEGE SCH. 101

GENERAL HOSPITAL, CO. 22ND, MARYLAND

101 PIEDMONT AVE.

DR. W. A. VAN ORDER

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00069 CERTIFICATE OF DEATH 00069

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART</b>		d. STREET ADDRESS <b>724 MARYLAND AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH</b>		First Middle Last <b>ROGERS</b>		4. DATE OF DEATH Month Day Year <b>1 8 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-30-08</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days <b>17 days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Raliroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA Monongah</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BRUCE ROGERS</b>		14. MOTHER'S MAIDEN NAME <b>Ada Gandy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-09-8175</b>		17. INFORMANT <b>PT'S CHART</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial Infarction, acute, anteroapical</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>17 days</b> <b>17 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 23, 1961</b> to <b>Jan 8, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 8, 1962</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>S. G. Weisman</b>		M.D. <b>S. G. WEISMAN, M.D.</b>		22b. DATE SIGNED <b>1/9/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN, M.D.</b>		22d. ADDRESS <b>59 GREENE ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>I-12-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Lodge Cemetery Shinnston, W.Va.</b>	
23d. LOCATION (City, town or county) (State) <b>Shinnston, W.Va.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 '62</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>					

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THE STATE OF TEXAS,  
COUNTY OF DALLAS,  
I, the undersigned, Clerk of the County Court,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
County Court of the County of Dallas, State of Texas,  
this 1st day of January, 1900.

CLERK OF COUNTY COURT.

W. J. KIRKMAN, J. C.

1-1-00

Wm. J. Kirkman, J. C.

1-1-00

Wm. J. Kirkman, J. C.

1-1-00



FOR STATE  
DEPT. FILE  
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AMERICAN EXCHANGE BANK OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be signed by the hospital or attending physician. Page 5 is to be signed by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00071

00071

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK *MEMORIAL</b>			d. STREET ADDRESS <b>231 NATIONAL HIGHWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNICE E. SHANER</b>			4. DATE OF DEATH Month Day Year <b>1-21- 19 62</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1907</b>		9. AGE (In years last birthday) yrs. <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ROCKWOOD, PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>WILLIAM STERNER</b>			14. MOTHER'S MAIDEN NAME <b>GRACE MYERS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-20-6024</b>		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lungs (metastatic)</b> 170X DUE TO <b>Carcinoma Breast Rt.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>Jan 1961</b> , that (I) (we) last saw the deceased alive on <b>21 Jan 1961</b> , and that death occurred at <b>8:30AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>F. B. Whitworth</b> 22c. PHYSICIAN'S NAME (Type) <b>DR. F.B. WHITWORTH</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS		22b. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 23, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. JAMES F. SCARPELLI, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE <b>JAN 24 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



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00021

ALLGAWY COUNTY

WARRYLING

ALLGAWY

CUMBERLAND, MD.

12 DAYS

CUMBERLAND, MARYLAND

GENERAL HOSPITAL WARRYLING, 21 NATIONAL HIGHWAY

21 NATIONAL HIGHWAY

BERNICE

E. SHAW

1-11

WHITE

2-12-1907

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LEWIS

WARRYLING CO.

ROCKFORD, ILL.

GRACE WYERS

WILLIAM STERNER

215-20-0000 MEMORIAL HOSPITAL CUMBERLAND, MD.

*Carcinoma Breast R.  
Carcinoma Lungs (metastatic)*

*June 20 1961*

*Dr. F.B. Whitworth*

DR. F.B. WHITWORTH

James E. Scarnell, Cumberland, Md.

Cumberland, Md.

James E. Scarnell, Cumberland, Md.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00072

00072

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>BOWLING AVENUE, BOWLING GREEN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KAREN JANINE SHIPLEY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>1962</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 6, 1962</b>	9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LEO H. SHIPLEY</b>		14. MOTHER'S MAIDEN NAME <b>IRENE A. ANDERSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Promaturity</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan - 6, 1962</b> to <b>Jan - 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan - 7, 1962</b> , and that death occurred at <b>11:47 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>H. W. Eliason</b>		M.D.		22b. DATE SIGNED <b>January - 10 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. HAROLD W. ELIASON</b>		22d. ADDRESS <b>203 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/11/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park, Cumberland, Maryland</b>	
23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00073

00073

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVENUES</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>311 1/2 RACE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>BABY BOY</b>		<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>16</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JANUARY 12, 1962</b>	<b>9. AGE</b> (In years last birthday) yrs. <b>4</b>	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>4</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND CUMBERLAND</b>			
<b>13. FATHER'S NAME</b> <b>THOMAS T. SHIPWAY</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>776X</b> DUE TO <b>776X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>776X</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1-12-62</b> , <b>1962</b> , to <b>1-16-62</b> , <b>1962</b> , that (I) (we) last saw the deceased alive on <b>1-16-62</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>DR. HODGES.</b>		<b>22b. DATE SIGNED</b> <b>JAN 18 1962</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. HODGES.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 17, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fairview M.E. Cemetery</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 18 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Wm. L. Thane</b>			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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DR. HODGES

122 S. CENTRE STREET, WYLAND, MO.

James A. ...

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The funeral director must obtain the certificate from the attending physician and completely filled in. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The funeral director must obtain the certificate from the attending physician and completely filled in. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00074

00074

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>8Hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		d. STREET ADDRESS <b>Rt. #2</b>	
3. NAME OF DECEASED (Type or print) <b>ETHEL</b> First <b>A.</b> Middle <b>SHOEMAKE</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/1904</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Zihlman</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Lockard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. George Shoemake, Rt. #2, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>myocardial insufficiency.</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease. 4 yr.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>Jan 1, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 1, 1962</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Alvin J. Walters</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Alvin J. Walters M.D.</b>		22d. ADDRESS <b>48 Broadway, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/4/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery,</b>		23d. LOCATION (City, town or county) (State) <b>Eckhart Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montes</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>26 E. Main, Frostburg, Md.</b>	

10000

CERTIFICATE OF DEATH

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00075

00075

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN Ib <b>42 DAYS</b>		d. STREET ADDRESS <b>122 HANOVER ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARMICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>SHUCK</b>		<b>4. DATE OF DEATH</b> Month <b>JAN.</b> Day <b>30</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-27-1881</b>
<b>9. AGE</b> (In years last birthday) <b>80 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Rubber worker Goodyear Rubber Co.</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>JOSIAH SHUCK</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Maria LOUISA WHITE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>274-01-0373</b>	
<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL- CUMBERLAND, MD.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> <b>Generalized Intertrichosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 days</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>12</b> e.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Cumberland City, Md.</b>		<b>20f. City or town</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>12/19/61</b> to <b>1/30/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/30/62</b> , 19 <b>62</b> , and that death occurred at <b>1:48 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>DR. RICHARD J. WILLIAMS</b>		<b>22b. DATE SIGNED</b> <b>1/31/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. RICHARD J. WILLIAMS</b>		<b>22d. ADDRESS</b> <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Feb. 2, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Davis Memorial Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Hafer</b>		<b>25a. REC'D BY REGISTRAR</b> <b>FEB 6 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>		<b>25c. REGISTRAR'S SIGNATURE</b>	

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GENERAL HOSPITAL  
CENTRAL WAR HOSPITAL

12 DAYS

COVERING

122 WINDY ST.

CHUCK

WILLIAM

WHITE

27-1981

ASIAN SPARK

COLORED WHITE

*Handwritten signature*



*Handwritten signature*

DR. RICHARD J. WILLIAMS

122 S. CENTRE ST., CENTRAL WINDY

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00076

## CERTIFICATE OF DEATH

00076

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Luke</b>		c. LENGTH OF STAY in lb <b>44 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Luke</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>413 Pratt St.</b>				d. STREET ADDRESS <b>413 Pratt</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Effie</b> Middle <b>Mae</b> Last <b>Sively</b>				<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>30</b> Year <b>19 62</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 25, 1887</b>	
<b>9. AGE</b> (In years last birthday) <b>74</b>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cooks helper</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hospital</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Rockbridge Ct. Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William H. Kirkpatrick</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy J. Kelly</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>232-54-4573</b>		<b>17. INFORMANT</b> Address <b>Milton Sively-Luke, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8 Cancer of the large bowel</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>Fractured Hip</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Hip</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks known</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1962 to Jan 30, 1962, that (I) (we) last saw the deceased alive on 1-30-1962, and that death occurred at 3:55 PM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>William W. Lesh</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2-1-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Wm. W. Lesh</b>				<b>22d. ADDRESS</b> <b>Westernport, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/1/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Philos</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Westernport Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ed. Boal</b>				<b>ADDRESS</b> <b>Westernport, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>	



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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00077

00077

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		d. STREET ADDRESS <b>Jackson Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ISABELLE STEINBAUGH</b>		<b>4. DATE OF DEATH</b> Month <b>1</b> Day <b>10</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/21/1875</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>
<b>11. BIRTHPLACE</b> (Country, State, or foreign country) <b>Lonaconing, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James Johnston</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Spiker</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Mr. Leroy Coleman, Lonaconing, MD.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>420.1</b> DUE TO <b>Arteriosclerotic CV disease Class III</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b> DUE TO (c) <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from Feb. 1956 to Jan 10, 1962 that (I) (we) last saw the deceased alive on Jan 10 1962, and that death occurred at 10AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>L.R. Miles, Jr.</b>		<b>22b. DATE SIGNED</b> <b>1/11/62</b>	<b>22c. PHYSICIAN'S NAME (Type)</b> <b>L.R. MILES, JR., M.D.</b>
<b>22d. ADDRESS</b> <b>LONACONING, MD.</b>		<b>22e. REC'D BY REGISTRAR</b> <b>JAN 15 '62</b>	
<b>22f. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>		<b>22g. DATE</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/12/1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Laurel Hill Cemetery</b>
<b>23d. LOCATION (City, town or county) (State)</b> <b>Moscow, MD.</b>		<b>23e. REC'D BY REGISTRAR</b> <b>JAN 15 '62</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>GEORGE EICHORN</b>		<b>24b. ADDRESS</b> <b>Lonaconing, MD.</b>	

MEDICAL CERTIFICATION

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1. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00078

00078

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b> <b>85x3</b>		d. STREET ADDRESS <b>151 S. MINERAL ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>BABY BOY STICKLEY</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 9, 19 62</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>1-8-1962</b>		9. AGE (In years last birthday) yrs. Months Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARL D. STICKLEY</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET L. KISER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fibrous Pleuritis</b> <b>76 2.00</b> DUE TO <b>Pulmonary fibrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral anoxia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/9/62</b> to <b>1/9/62</b> , and that (I) (we) last saw the deceased alive on <b>1/9/62</b> , and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Royce Hodges</b>				22b. DATE SIGNED <b>1-10-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. W. ROYCE HODGES</b>				22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-11-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Valley Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Keyser, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. Smith</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Clara L. Hume</b>	

2060422013

(M)

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00073

ALBANY

CLARKSON

TEMPERATURE & PULSE

MEMORIAL HOSPITAL

BABY

BOY

STICKLEY

JANUARY 3

1-3-1912

WHITE

CUMBERLAND, MD.

MARGARET L. KISLER

CARL D. STICKLEY

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*Formaldehyde*  
*Disinfectant*  
*10% solution*

1-10-12

122 S. CENTRE ST., CUMBERLAND, MD.

DR. V. ROYCE KODER

Botanico Valley  
Hospital Garden

Burial 1-1-12

Kodner, J. V.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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(I)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00079

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D. O. A. Memorial Hosp.</b>				d. STREET ADDRESS <b>227 So. Mechanic St.,</b>			
3. NAME OF DECEASED (Type or print) <b>PAUL CHESTER STICKLEY</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>12,</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1908</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supplyman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John M. Stickley</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes, W.W. # 2</b>				16. SOCIAL SECURITY NO. <b>705-09-9372</b>			
17. INFORMANT <b>Mrs. Mildred C. Stickley</b>				Address <b>Cumb. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/15/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				22d. LOCATION (City, town, or country) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR <b>Charles L. George</b>				24a. REC'D BY REGISTRAR <b>JAN 16 '62</b>			
ADDRESS <b>Cumberland, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Anthony L. Kinner</b>			

NO. 100,000,000

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00080

00080

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b <b>02 Cumberland,</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>710 Elm St.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b> d. STREET ADDRESS <b>619 Leiper St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>Riley Everhart Twigg</b>				<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>28,</b> Year <b>19 62</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 16, 1878</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> yrs. <b>IF UNDER 1 YEAR</b> Months <b>Days</b> <b>Hours</b> <b>Min.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grocery</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Green Ridge, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Levin Twigg</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Orlena Nicely</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>				<b>16. SOCIAL SECURITY NO.</b> <b>232-10-9188</b>				<b>17. INFORMANT</b> <b>Mrs. Markwood Chaney</b>		<b>Address</b> <b>710 Elm St., Cumb. Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>450-1</b> DUE TO <b>trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>gangrene lower extremities</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>5 yrs</b> <b>3 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 24, 19 62</b> <b>5:45P</b> <b>to</b> <b>Jan 28, 19 62</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Jan 24, 19 62</b> <b>and that death occurred at</b> <b>5:45P</b> <b>M</b> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Clay E. Durrett M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>1/29/62</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Clay E. Durrett M.D.</b>				<b>22d. ADDRESS</b> <b>236 Va. Ave., Cumberland, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/31/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Maryland</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles L. George</b>				<b>ADDRESS</b> <b>Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 31 62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>			

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00081

00081

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MC COOLE</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALBERT</b>		First		Middle <b>VINEY</b>		Last		4. DATE OF DEATH Month <b>JANUARY</b>		Day <b>8</b>		Year <b>1962</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 8, 1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b>		Days <b>71</b>		IF UNDER 24 HRS. Hours <b>71</b>		Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tipple Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LUKE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>JAMES VINEY</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CROWTHERS</b>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-03-3892</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>5 years</b>																INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>1 - 2</b> ....., 1962 to <b>1 - 8</b> ....., 1962, that (I) (we) last saw the deceased alive on <b>1 - 8</b> ....., 1962, and that death occurred <b>9:30 AM</b> from the causes and on the date stated above.																	
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>1-8-62</b>		22c. PHYSICIAN'S NAME (Type) <b>RALPH W. BALLIN</b>		22d. ADDRESS <b>62 GREENE ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11 Jan 62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Valley Memorial</b>		23d. LOCATION (City, town or county) <b>Keyser, W. Va.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Allen M. Potruich</b>		ADDRESS <b>Keyser, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

(M)

(1)

1908

DEPARTMENT OF HEALTH

1908

ALLEGANY

WYAND

ALLEGANY

CUMBERLAND

5 DAYS

MC COOLE

MEMORIAL HOSPITAL

ALBERT

VINEY

JANUARY 5

MALE WHITE

BOY 5.100

II

Tipple Foreman

WYAND

LIND, WYAND

U.S.A.

JAMES VINEY

SARAH CROTHERS

1908-01-20

MEMORIAL HOSPITAL, CUMBERLAND, MD.

9 years

Concessive heart failure

Arteriosclerotic atherosclerotic disease 5 years

x

1 - 2 1 - 3 1 - 4

1 - 5 1 - 6

1-2-3

x

25 GREEN ST., CUMBERLAND, MD.

REPH W. GALLIN

Funeral 11 Jan 08

Paterson Valley Memorial, KY.

Jan 2 08

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

00082  
00082  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>30 N. Lee St.,</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b> d. STREET ADDRESS <b>30 N. Lee St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanor</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>14,</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1867</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	9. AGE (In years last birthday) <b>94</b> IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael Yupa</b>		14. MOTHER'S MAIDEN NAME <b>Johanna ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Helene M. Jones</b>		Address <b>30 N. Lee St., Cumb.</b> <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>JANUARY 14, 1962</b> ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b> Address (Street, city, town, or county) <b>R 9 CUMBERLAND, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/17/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b> 24a. REC'D BY REGISTRAR <b>JAN 17 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00083

00083

1. PLACE OF DEATH a. COUNTY <b>ALEEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>334 BALTIMORE AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>SALLY E WELSH</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 7 19 62</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>MARCH 2, 1878</b>		9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LLOYD BUCY</b>			
14. MOTHER'S MAIDEN NAME <b>JENNIE WOLFORD</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>490X DUE TO Bacteremia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Labar Pneumonia</b> (a), stating the underlying cause last. (c) <b>Due to</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Insulin</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3:10 PM</b> , 19 <b>62</b> , to <b>DEATH</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>JAN 9</b> , 19 <b>62</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>L. Michael Ghick</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GHICK</b>		22d. ADDRESS <b>126 N. SMALLWOOD CUMBERLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 9, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALD HILL CEMETERY</b>	
23d. LOCATION (City, town or county) <b>ROUTE 3, BEDFORD, PA.</b>		23e. (State) <b>PA.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>					



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TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00084					00084						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		Allegany			a. STATE		Maryland				
		MARYLAND			b. COUNTY		Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Cumberland			12/6/1961		Cumberland						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Allegany County Infirmary					430 Pine Place						
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year	
Conrad					Wenteroth	January		6,	19	62	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/21/1877		84 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Retired Fireman			Potomac Edison Co.			Cumberland, Maryland			U. S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Louis Wenteroth					Annie Heavener						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No			217-10-9050		P.O. Box 599		Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic degeneration											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b) arterio-sclerotic cerebral degeneration											
DUE TO (c) Cholecystitis, chronic											
DUE TO (c) Senile psychosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
Month, Day, Year			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
Hour a.m. p.m.			19								
21. I certify that (I) (this hospital) attended the deceased from 12/6/61, 19, to 1/6/62, 19, that (I) (we) last saw the deceased alive on 1/5/62 @ 6:00 A. M., and that death occurred at 12/6/61, 19, from the causes and on the date stated above.											
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS			1/6/1962			
Dr. Lee B. Mathews					49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		1/8/62		Greenmount Cemetery		Cumberland		Md			
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John F. Hafer					Cumberland Md		DATE JAN 12 '62		Arthur S. Thomas		

(M)

00084

00084

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany County Jail

Allegany County Jail

Allegany

Allegany

Allegany

Male

White

11/21/1917

34

Allegany County Jail records

1/6/52

12/6/51

1/2/52 6:00 A.M.

1/6/1952

Allegany County Jail

Dr. H. H. Hobbins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician.  
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15M 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
00085					00085					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 HR. 12 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			d. STREET ADDRESS <b>OAKWOOD AVE., ROBERT'S PLACE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>ANGELA</b> Middle <b>Agnes</b> Last <b>WIGFIELD</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>19 62</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 1, 1914</b>		9. AGE (In years last birthday) <b>47</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWFE. &amp; REG. NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home, Hosp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ECKHART, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>SAMUEL ROBINSON</b>					14. MOTHER'S MAIDEN NAME <b>ANNA Byrnes</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <b>Hypertensive Arteriosclerotic Vascular Dis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Several hours</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-5-1962</b> to <b>1-25-1962</b> that (I) (we) last saw the deceased alive on <b>1-25-1962</b> and that death occurred at <b>2:12 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>W. F. Williams</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>1-25-62</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>					22d. ADDRESS <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/27/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>					ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 29 '62</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. George</b>	

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60083

ALLEGARY

CHERRY

MEMORIAL HOSPITAL

ANGEL

FRANKS WHITE

WHITE, A. R. & S. R.

SAUL ROBINSON

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YING

WILLIAM

ONE FIVE, HOSP. BECKHART, MARLTON

APRIL 1, 1914

LOVELL

JANUARY 25

DARKWOOD AVE., ROBERTS PLACE

CAMERLAND

WRIGHT

ALLEGARY

MEMORIAL HOSPITAL

60083

DR. V. L. WILLIAMS

123 S. CENTRE STREET, CAMERLAND, TEX.

1/1/21

CHARLES L. GEORGE

22. ROSS - 1st. CAMERLAND, TEX.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00086

00086

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, write name and address) <b>MEMORIAL HOSPITAL AVES.,</b>				d. STREET ADDRESS <b>36 ROBERTS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE Lavena WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 21 1962</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4, 1889</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Columbia Furnace, Va. U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>NELSON FADLEY</b>			
14. MOTHER'S MAIDEN NAME <b>ANNIE WOODROW</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland Allegany Md.</b>		20f. CITY or town (County) (State) <b>Cumberland Allegany Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/1/62</b> 19..... to <b>1/21/62</b> 19....., that (I) (we) last saw the deceased alive on <b>1/20/62</b> 19....., and that death occurred at <b>9:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED <b>1/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				22d. ADDRESS <b>122 SOUTH CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery,</b>		23d. LOCATION (City, town or county) (State) <b>Fort Ashby, W. Va.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 25 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

(M)

00082

ALLIANCE

CL. 10/10/10

11 DAYS

MEMORIAL HOSPITAL

WASHINGTON, D.C.

30 ROBERTS STREET

BRIDGE

BRIDGE

WILLIAMS

JANUARY 21

FORM 10

WHITE

MARCH 1, 1932

15

U. S. A.

NELSON, ABILEY

WILLIAMS, WOODROW

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

*Confidential*

*1/10/32*

DR. R. A. WILLIAMS

122 SOUTH 25TH ST. CUMBERLAND, MD.

Charles E. George, Chairman

1/10/32

TO HOSPITAL CONTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN lb <b>4/9/1959</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			d. STREET ADDRESS <b>430 Columbia Street</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Elizabeth E. Wilson</b>					4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1962</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/8/1884</b>		9. AGE (In years last birthday) <b>78</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						
13. FATHER'S NAME <b>Anthony Shriver</b>					14. MOTHER'S MAIDEN NAME <b>Catherine O'Shea</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>none</b>					17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial, chr. degenerative</b> <b>584X</b> DUE TO (b) <b>arteriosclerosis &amp; cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Cholelithiasis - Senile psychosis</b>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/9/59</b> 19....., to <b>1/12/62</b> 19....., that (I) (we) last saw the deceased alive on <b>1/12/62</b> 19....., and that death occurred at <b>8:20 P.M.</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>Dr. Lee B. Mathews</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-13-62</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee B. Mathews</b>					22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>									
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/15/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md.</b>					ADDRESS <b>Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>					

00083

STATE OF MARYLAND

00081

Allegany

Maryland

Chesapeake

130 Columbia Street

X

January 12, 1962

Wilson

70

1/8/1984

U. S. A.

Maryland

Catherine O'Ghera

70 Box 299 Chesapeake, Md.

Allegany County Intimacy records.

Allegany

Chesapeake

1/2/1959

Allegany County Intimacy

Elizabeth E.

X

White

Female

Honorable

Anthony Shriver

1/12/62

1/9/59

1/12/62

Dr. Joe B. Matthews

10 Greene St., Chesapeake, Md.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00088

CERTIFICATE OF DEATH

00088

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b <b>02</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>302 So. Allegany St.,</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b> d. STREET ADDRESS <b>1 302 So. Allegany St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JOHN FERMAN WINTERS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>Jan. 3, 19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 23, 1890</b> <b>71</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Plumbing Frm.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Celanese Corp.</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Cumberland, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>George W. Winters</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Gertrude Long</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes, W. W. # 1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-10-5192</b>	
<b>17. INFORMANT</b> <b>Miss, Margaret L. Winters</b>		<b>Address</b> <b>Cumb. Md. 302 S. Allegany</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis -</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	<b>20f. (City or town)</b> _____ (County) _____ (State) _____
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1958</b> <b>19</b> <b>10:45P</b> <b>1962</b> <b>1/3</b> <b>1962</b> <b>1/3</b> <b>that (I) (we) last saw the deceased alive on</b> <b>1-3-</b> <b>1962</b> <b>and that death occurred at</b> <b>10:45P</b> <b>M</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>L. B. Mathews M.D.</b>		<b>22b. DATE SIGNED</b> <b>1/4/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>L. B. Mathews M.D.</b>		<b>22d. ADDRESS</b> <b>49 Greene St., Cumberland, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>1/6/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>	<b>23d. LOCATION</b> (City, town or county) _____ (State) _____ <b>Cumberland, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Wayne George</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 8 '62</b>	
<b>ADDRESS</b> <b>Cumberland, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>	

00088



M. W. and George Campbell, Inc.

11101st Street, N. W.

Washington, D. C.

Telephone 11101

11101st Street, N. W.

Washington, D. C.

Telephone 11101

11101st Street, N. W.

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11101st Street, N. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00089 CERTIFICATE OF DEATH 00089														
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			d. STREET ADDRESS <b>54 McCULLOH STREET</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>54 McCULLOH STREET</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>MARGARET S. YATES</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>31</b> Year <b>1962</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 7th, 1889</b>		9. AGE (In years last birthday) <b>72</b> rs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOUSEWORK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>HENRY O. STEVENS</b>					14. MOTHER'S MAIDEN NAME <b>SARAH DAVIS</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address <b>GRAHAMTOWN, MRS. GLADYS KLOSTERMAN, FROSTBURG, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Dilatation</b> <b>443X</b> DUE TO (b) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13, 1962</b> to <b>Jan 31, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 13, 1962</b> and that death occurred at <b>10:55 P.M.</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>Feb 2, 1962</b>				
22a. SIGNATURE <b>W. O. McLane</b>					M.D. <b>W. O. McLane</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-3-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>		23d. LOCATION (City, town or county) <b>FROSTBURG,</b>		(State) <b>MD.</b>						
24 FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Dunt</b>					ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>					

125410

9300